Commonwealth of Massachusetts
Department of Public Health, Bureau of Health Professions Licensure
Drug Control Program
239 Causeway Street, Suite 500, Boston, MA 02114
Telephone 617-973-0949 Fax 617-753-8233

Application for Massachusetts Controlled Substances Registration for Ambulance Services

This Massachusetts Controlled Substances Registration (MCSR) application is for ambulance services to request to carry, handle, store, and dispense controlled substances, in accordance with their level of licensure, including substances in Schedules II, IV, VI. Additionally, ambulance services can request to carry the Schedule III substance, Ketamine. Ketamine shall only be carried in an amount to be used as outlined in the Statewide Treatment Protocols (STP). https://www.mass.gov/lists/emergency-medical-services-statewide-treatment-protocols

An MCSR is required for each principal place of business, e.g., satellite station or place of garaging. Registrations are site specific.

Please be sure to:

- Submit completed application form.
- Enclose check or money order for $300 made payable to "Commonwealth of Massachusetts".
- Enclose a copy of the service's hospital affiliation agreement and a copy of the department or service's drug security policies.
- Have the form signed (not initialed) and dated.
- Mail to the address above.

Incomplete applications will be returned causing a delay in issuance of the MCSR(s). Only send copies of supporting documents. Do not send originals as they will not be returned.

For further information, visit: www.mass.gov/orgs/massachusetts-controlled-substances-registration.

Application Type: (Please select one) ❑ New ❑ Renewal ❑ Amended Information

In the boxes below enter the requested information.
1) Applicant: (Ambulance Service Name)
2) Ambulance Location: (Applications with a P.O. Box number and no street address cannot be processed.) Street: City: State: ZIP:
3) Corporate Name: Address: Street: City: State: ZIP: Name and Title of Corporate Contact Person: *The MCSR certificate will be mailed to the Corporate Contact Person at the Corporate Address.*
4) Business Telephone No.: ( ) area code
5) Business Email Address:

6) Federal Tax ID No.: (Required by M.G.L. c. 30A, s. 13A)

7) Massachusetts Controlled Substances Registration No. (For renewal applications):

8) Massachusetts Department of Public Health Ambulance Service License No.:

9) Ambulance Classification (check all that apply):

- ❑ ALS-Paramedic: Schedules II, IV, VI
- ❑ ALS-Paramedic: Schedule III-Ketamine
- ❑ ALS-Advanced: Schedule VI only
- ❑ BLS-Basic: Schedule VI only

***Schedule VI includes all prescription drugs not in Schedules II – V, including Epinephrine and Naloxone.**

10) Name and Address of hospital pharmacy supplying emergency medication:

11) Total number <u>at this</u> location of:	a) All EMTs	b) EMT-Basics	c) Advanced EMTs	d) Paramedics

12) Describe the manner in which all controlled substance drug products will be secured:

13) Describe the frequency and how the controlled substance drug products will be replenished:

14) I have enclosed a copy of the service's hospital affiliation agreement and a copy of the department or service's drug security policies. ❑ Yes ❑ No

15) Has the applicant ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances? ❑ Yes * ❑ No

16) Has any professional license or registration held by the applicant under any name or corporate name or legal entity been surrendered, revoked, suspended or denied or is such action pending? ❑ Yes * ❑ No

* A"Yes" to Question No. 15) or No. 16) requires a letter of explanation to be attached to this application.

I hereby certify that the information on this application is true to the best of my knowledge, and that the applicant will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health. I also certify, in accordance with M.G.L. c. 62C, section 49A, that the applicant has to the best of my knowledge and belief complied with all laws of the commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting of child support.
Signed under the pains and penalties of perjury.

Signature of authorized individual _____ Date _____

Print Name: _____

Title: _____

For Office Use Only	
Application approved by:	Comments:
Date:	